Hope Chiropractic

"Giving you hope, improving health, and creating wellness"
Dr. Carolyn M. Wanken

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept the patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: a state of optimal physical, mental, and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider. If treatment is determined not medically necessary you are held responsible for those charges.

All health care procedures carry some risk. Risks are associated with chiropractic care and may include but are not limited to, muscle or ligament injuries, nerve injuries, vascular injuries and fractures. Alternatives to chiropractic care may include medications, surgery and other alternative treatments.

Regardless of what the disease is called, we do not offer to treat it nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustment.

I, _____, have read and fully understand the above statements. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ **(signature)** _____ **(date)**

Consent to evaluate and adjust a minor child

I, _____**,** being the parent or legal guardian of _____ have fully read and fully understand the above terms of acceptance and herby grant permission for my child to receive chiropractic care.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand the under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information.

I have the right to obtain a copy of the Notice of Privacy Practices. I understand that Hope Chiropractic has the right to change its Notice of Privacy Practices from time to time and that I may contact Hope Chiropractic at any time at the address below to obtain a current copy of the Notice of Privacy Practice.

☐ I authorize and give permission to the following individuals to have conversations with Hope Chiropractic regarding my protected health information.

☐ I authorize and give permission to the following individuals to have access to my protected health information.

☐ I authorize and give permission to the following individuals to pick up my protected health information.

DOB _____

DOB _____

I authorize and give permission to the following individuals to have access to my protected health information.

I authorize and give permission to the following individuals to pick up my protected health information.

Photograph & Video Release

☐ I hereby give permission for Hope Chiropractic to display my OR my child's photograph or video testimonial in the office and for marketing on our website, YouTube, Facebook, etc. I may request the photo or video to be removed from the public at any time.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Witness: _____

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